Personal Representative Designation

Recipient's Name:_____

SSN / Senior Rx or Nevada Disability Rx ID #: _____

I hereby designate the following individual as my Personal Representative:

_____

(Print Name)

And as such, I allow and authorize the Nevada Department of Health and Human Services, Senior Rx or Disability Rx program to disclose my health information that is protected by federal privacy regulations; specifically, all information held in a designated record set by Senior Rx or Disability Rx or its business associates. I further authorize my personal representative, named above, to represent me and my interests with Senior Rx or Disability Rx. As my personal representative, the above named person has the same rights to access, inspect, obtain a copy, request restrictions on disclosures, request amendments or corrections, request an accounting of disclosures, and request alternative means or location of communications as I have as the subject of the personal protected health information.

I understand that federal privacy regulations do not apply to the individual I have designated as my personal representative and that protected health information disclosed to this individual may be subject to further disclosure without my explicit authorization.

This Authorization is valid and in effect until I provide written notice to Senior Rx or Disability Rx that I no longer wish this individual to represent me.

I release the Nevada Department of Health and Human Services, Senior Rx or Disability Rx program from any liability resulting from authorized disclosure of information to my personal representative. A copy of this Authorization can serve as an original.

_____ _____

Signature of Recipient Date